CENTERSTOI	THEDICARE & MEDICAID SERVICES			OND NO. 0750-0571
STATEMEN	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:		00	COMPLETED
	15G327	A. BUILDING	08/25/2011	
	130327	B. WING		00/23/2011
NAME OF I	OD OUTDED OR GUIDNIED	STREET.	ADDRESS, CITY, STATE, ZIP CODE	•
NAME OF I	PROVIDER OR SUPPLIER	417 N A	ASH ST	
COMMIT	NITY LIVING INC		ER, IN46721	
COMMO	INIT I LIVING INC	BOILE	IN, 11140721	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDENCE BY AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	REGULATORI OR ESCIDENTIFTING INFORMATION)	IAG		DAIL
W0000				
1	This visit was for a fundamental	W0000	İ	İ
		*************************************		
	recertification and state licensure survey.			
	Survey dates: August 22, 23, 24, and 25,			
	2011			
	E 11, N. 1 000045			
	Facility Number: 000845			
	Provider Number: 15G327			
	AIMS Number: 100243810			
	Alivis Number. 100243810			
	Surveyor: Kathy Craig, Medical Surveyor			
	III			
	The following deficiencies also reflect			
	state findings under 431 IAC 1.1.			
	Quality Review completed 9/6/11 by Ruth			
	Shackelford, Medical Surveyor III.			
	Shackehord, Wedicar Surveyor III.			
			1	
11/0104	The governing hady must eversing series!		1	-
W0104	The governing body must exercise general			
	policy, budget, and operating direction over			
l	the facility.		1	
		W0104		09/23/2011
			W 104 483.410(a)(1)	1
	Based on observation and interview, for 6 of 6		GOVERNING BODY	
	clients (clients #1, #2, #3, #4, #5, and #6) who		GOVERNING BODY	
	resided in the home, the governing body failed to			
	exercise operating direction over the group home		The governing body exercise	es
ı	1 operating an ection over the group nome	1	1	ı

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		LDING	00	COMPLETED		
		15G327	B. WIN	IG		08/25/2011		
NAME OF	PROVIDER OR SUPPLIEI	3	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
			417 N ASH ST					
COMMU	NITY LIVING INC			BUTLE	R, IN46721			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
TAG	<b>+</b>	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE		
	to ensure maintenance needs were addressed.				general policy, budget, and			
	F: 1: : 1 1				operating direction over the			
	Findings include:				facility.			
	Observations were conducted at the group home							
		2, #3, #4, #5, and #6 resided on						
		PM to 6:15 PM. The following			System to Prevent Recurre	maa.		
	observations of the	environment in the home			System to Trevent Recurred	ice.		
	included:				The Quality Assurance Team	1		
		he sink were worn and had			reviewed this citation and the	I		
	chipped wood.	ahan drawar by the -i-1-			environmental concerns which	1		
	<ul><li>2. One squeaky kitchen drawer by the sink.</li><li>3. Kitchen counter tops were worn with scratches on them.</li></ul>				have arisen in this facility. T			
					existing procedure to correct			
	4. Client #4 and #5's bedroom had numerous dark				environmental needs places t	I		
	stains on their light				responsibility on the house			
		's bedroom wall by the light			manager to identify and to			
	switch had 29 pin s	ized holes on it			request improvements, repair	rs.		
	6. Hallway carpet	was stained throughout and			and replacement of furniture	·		
	worn.				through the process of work			
		m chairs were worn with			orders to maintenance and to	the		
	of the chair backs w	nem and the backs wobblyone			QA Team, itself. In addition	1		
		had stains and it had a			QMRP is responsible for assi			
		It side, under the arm, and it			that the environmental aspec	-		
		nterview on 8/22/11 at 4:30 PM			the facility are up to date and			
	· ·	I the substance on the side of			within agency guidelines.			
		neone picking their nose."			Although this has been the			
		se manager on 8/22/11 at 4:31			procedure for twenty-five ye	ars		
		aintenance man had told him			and has generally proved			
	that was not what that was on the side of the couch.) Also, there was a matching blue chair with stains all over it.  9. Two chairs in family room were scratched.  10. The small wooden table in the family room was wobbly.  11. The white trim on the doorway by the				successful, the process some	how		
					broke down during the past y			
					in this home. The QA Team			
					that it is necessary to incorpo			
					another layer of checks and			
					balances into the system whi	ch		
	1	pped paint on the bottom and			will safeguard and prevent fu			
	was stained.				lapses. The Agency uses an			
	12. Microwave star	nd was worn and had chipped			environmental checklist for t	he		
	11 "							

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		15G327	1			08/25/2011	
		1	B. WIN		A DODEGO CITY CTATE THE CODE		
NAME OF F	PROVIDER OR SUPPLIEI	R		l	ADDRESS, CITY, STATE, ZIP CODE		
				417 N A			
COMMUNITY LIVING INC			BUTLER, IN46721				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	wood pieces.		İ		non-Medicaid services provi	ded	
					to Waiver Consumers, and it	is	
	Interview on 8/22/1	1 at 4:10 PM with the house			believed that the use of the 9	00	
	-	icted. He stated he thinks "the			day checklist will prevent		
		ly 24 years old." He indicated			recurrence in this home and	in	
	-	ted on in the past. The house			the other group homes. The		
		he agreed the above-mentioned			maintenance director will	,	
	items needed to be	repaired or replaced.					
					perform the environmental	1	
		1 at 12:50 PM with the QMRP			survey every 90 days using t		
		Retardation Professional) was			Environmental Checklist. Ir	1	
		licated she did not know if			addition, house managers,		
	-	ntenance requests for the group			QMRP's and management st		
		ot know how often the carpet			will have the checklist availa	able	
	and furniture were cleaned.				to report on the physical		
	Interview on 9/24/1	1 of 11:45 AM with the house			environmental needs of the		
		1 at 11:45 AM with the house			homes, as they occur.		
	-	ucted. He indicated there were uests put in for the above items			Maintenance will be respons	ible	
		as client's bedroom walls to be			for repairs and upkeep, and		
		oved out (which would be client			requests for replacing furnity	ıre	
	#1 and #3's bedroom				and appliances will be forwa		
		n now).			with the checklist to the QA	irucu	
	1.1-3-1(a)				_	l	
	1.1 5 1(u)				Team which convenes week	ıy.	
					Demonsible CEO OA Tee		
					Responsible: CEO, QA Tea	ım	
					G 1 . 1 . 00/12/2011		
					Completed: 09/13/2011		
					1 411		
					1. All environmental finding		
					including furniture, counter	•	
					and flooring replacement, ci		
					during the observation of 8/2	22/11	
					have been corrected.		
			1				

PRINTED: 09/26/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 A. BUILDING 15G327 08/25/2011 B. WING

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 417 NASH ST

COMMUNITY LIVING INC			417 N ASH ST BUTLER, IN46721			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
			Responsible: Maintenance  Completed: 09/23/2011  2. An environmental checklist is developed to be used every 90 days by maintenance staff.  Responsible: CEO			
W0322	The facility must provide or obtain preventive and general medical care.		Completed: 09/13/2011			
	Based on record review and interview, the facility failed for 1 of 3 sampled clients (client #2) by not ensuring he received preventive prostate care.  Findings include:  Review on 8/23/11 at 11:50 AM of client #2's records was conducted. Client #2's ISP (Individual Support Plan) dated 10/25/10 indicated client #2 was 56 years of age. There was no PSA (prostate lab test) in his record. Client #2's annual physical dated 9/29/10 indicated "males after age 50 PSA test yearly." It was not checked at the physical exam and no	W0322	W322 483.460(A)(3) PHYSICIAN SERVICES The facility provides and obtains preventative and general medical care. System to Prevent Recurrence: The QA Team reviewed this finding and believes that the usual agency practice of testing the PSA of male Consumers over the age of fifty did not occur because Client#2 was a new resident and the PSA test was overlooked in the initial physical exam done by the Client's own physician given prior to the Client's moving into the home. Our Residential staff are trained to request the PSA during the routine annual physical exam for males over fifty and the Team is	09/13/2011		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1J4T11

Facility ID:

000845

If continuation sheet

Page 4 of 9

INTELLETION CONFIDENCE   156327   Name   156	STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE S	(3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY LIVING INC  VAID  SUMMANY STATEMENT OF DEFICIENCIES  BUTLER, INA6721  BUTLER, INA6721  SUMMANY STATEMENT OF DEFICIENCIES  BUTLER, INA6721  REGULATORY OR LSC IDENTIFYING REGONATION)  TAG  REGULATORY OR LSC IDENTIFYING REGONATION)  TEST BUTLER, INA6721  REGULATORY OR LSC IDENTIFYING REGONATION)  TEST BUTLER, INA6721  COMMUNITY LIVING INC  (S)  COMMUNITY LIVING INC  SUMMANY STATEMENT OF DEFICIENCIES  BUTLER, INA6721  PRITTY  COMMUNITY LIVING SIMMANY STATEMENT OF DEFICIENCIES  BUTLER, INA6721  COMMUNITY LIVING SIMMANY STATEMENT OF DEFICIENCIES  BUTLER, INA6721  COMMUNITY LIVING SIMMANY STATEMENT OF DEFICIENCIES  BUTLER, INA6721  COMMUNITY LIVING SIMMANY STATEMENT OF DEFICIENCIES  BUTLER, INA6721  COMMUNITY LIVING SIMMANY STATEMENT OF DEFICIENCIES  BUTLER, INA6721  COMMUNITY LIVING SIMMANY STATEMENT OF DEFICIENCIES  BUTLER, INA6721  COMMUNITY LIVING SIMMANY STATEMENT OF DEFICIENCIES  BUTLER, INA6721  COMMUNITY LIVING SIMMANY STATEMENT OF DEFICIENCIES  BUTLER, INA6721  COMMUNITY LIVING SIMMANY STATEMENT OF DEFICIENCIES  COMMUNITY LIVING SIMMANY STATEMENT OF DEFICIENCIES  COMMUNITY LIVING SIMMANY STATEMENT OF DEFICIENCIES  COMMUNITY LIVING SIMMANY STATEMENT OF DEFICIENCIES  COMMUNITY LIVING SIMMANY STATEMENT OF DEFICIENCIES  COMMUNITY LIVING SIMMANY STATEMENT OF DEFICIENCIES  COMMUNITY LIVING SIMMANY STATEMENT OF DEFICIENCIES  COMMUNITY LIVING SIMMANY STATEMENT OF DEFICIENCIES  COMMUNITY LIVING SIMMANY STATEMENT OF DEFICIENCIES  COMMUNITY LIVING SIMMANY STATEMENT OF DEFICIENCIES  COMMUNITY LIVING SIMMANY STATEMENT OF DEFICIENCIES  COMMUNITY LIVING SIMMANY STATEMENT OF SECURO SIMMANY SIM	AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A BUILDING 00		00	COMPLETED	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY LIVING INC  UNAPPERS (EACH DEFICIENCY MIST BE PERCEDED BY FULL TAG REQULATORY OR LIST IDENTIFYING INFORMATION)  TREETY (EACH DEFICIENCY MIST BE PERCEDED BY FULL TAG REQULATORY OR LIST IDENTIFYING INFORMATION)  TREOTY WAS available for review of a PSA test being done since client turned 50 years old.  Interview on 8/23/11 at 12:50 PM with the QMRP (Qualified Mental Retardation Professional) was conducted. She indicated she didn't believe client #2 has had a PSA.  1.1-3-6(a)  There must be an active program for the prevention, control, and investigation of infection and communicable disease.  Based on observation and interview, the facility failed for 2 of 3 sampled clients (clients #1 and #2) by not ensuring they used proper sanitation methods while cooking or setting the table.  Findings include:  Observations were conducted on 8/22/11 from 4:00 PM to 6:15 PM at the group home. Client #1 gat out at bag of frozen chicken nuggels and poured them onto a baking pan, using his bare hands to scrape some of them onto the pan. Client #1 had not washed his hands before handling the conductions of the pan. Client #1 had not washed his hands before handling the conducted this conducted in the conduction of the pan. Client #1 had not washed his hands before handling the conducted hand to scrape some of them onto the pan. Client #1 had not washed his hands before handling the conducted hand to scrape some of them onto the pan. Client #1 had not washed his hands before handling the conducted handling the conduct	15G327		15G327	I 08/25/2011			011	
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Description   Communication   Computer   C	NAME OF P	PROVIDER OR SUPPLIER						
REETX   REGULATORY OR I. SCI DEPATRY INFORMATION   TECOMY was available for review of a PSA test being done since client turned 50 years old.   Confident that the PSA would have been performed at the next annual physical exam, but the process broke down during this instance when the physical was obtained before the regular staff were involved. The QA team believes that recurrence of this lapse will be prevented by having the agency nurse attach a note to the 450B physical exam form for any prospective male clients over the age of fifty years old.   Responsible: Team Leader Completed: 09/08/2011	COMMUN	NITY LIVING INC						
record was available for review of a PSA test being done since client turned 50 years old.  Interview on 8/23/11 at 12:50 PM with the QMRP (Qualified Mental Retardation Professional) was conducted. She indicated she didn't believe client #2 has had a PSA.  1.1-3-6(a)  There must be an active program for the prevention, control, and investigation of infection and communicable diseases.  Based on observation and interview, the facility failed for 2 of 3 sampled clients (clients #1 and #2) by not ensuring they used proper sanitation methods while cooking or setting the table.  Findings include:  Observations were conducted on 8/22/11 from 4:00 PM to 6:15 PM at the group home. Client #1 got out a bag of frozen chicken nuggets and poured them onto a baking pan, using his bare hands to scrape some of them onto the pan, Client #1 had not washed his hands before handling the		SUMMARY S	TATEMENT OF DEFICIENCIES	ID				(X5)
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test being done since client turned 50 years old.  Interview on 8/23/11 at 12:50 PM with the QMRP (Qualified Mental Retardation Professional) was conducted. She indicated she didn't believe client #2 has had a PSA.  1.1-3-6(a)  There must be an active program for the prevention, control, and investigation of infection and communicable diseases.  Based on observation and interview, the facility failed for 2 of 3 sampled clients (clients #1 and #2) by not ensuring they used proper sanitation methods while cooking or setting the table.  Findings include:  Observations were conducted on 8/22/11 from 4:00 PM to 6:15 PM at the group home. Client #1 got out a bag of frozen chicken nuggets and poured them onto a baking pan, using his bare hands to scrape some of them onto the pan. Client #1 had not washed his hands before handling the	TAG		· · · · · · · · · · · · · · · · · · ·		TAG			DATE
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Professional) was conducted. She indicated she didn't believe client #2 has had a PSA.  1.1-3-6(a)  1.1-3-6(a)  There must be an active program for the prevention, control, and investigation of infection and communicable diseases.  Based on observations methods while cooking or setting the table.  Findings include:  Observations were conducted on 8/22/11 from 4:00 PM to 6:15 PM at the group home. Client #1 got out a bag of frozen chicken nuggets and poured them onto a baking pan, using his bare hands to scrape some of them onto the pan. Client #1 had not washed his hands before handling the						_		
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had a PSA.  1.1-3-6(a)  There must be an active program for the prevention, control, and investigation of infection and communicable diseases.  Based on observation and interview, the facility failed for 2 of 3 sampled clients (clients #1 and #2) by not ensuring they used proper sanitation methods while cooking or setting the table.  Findings include:  Findings include:  Findings include:  The Agency maintains an active program for the program for the prevention, control, and investigation of infection and communicable diseases.  The Agency maintains an active program for the prevention, control, and investigation of infection and communicable diseases.  System to Prevent Recurrence:  System to Prevent Recurrence:  The QA Team reviewed this		indicated she didn't believe client #2 has						
1.1-3-6(a)  1.1-3-								
the age of fifty years old. Responsible: QA Team Completed: 09/13/2011 1. A PSA exam for Client#2 is completed. Responsible: Team Leader Completed: 09/08/2011  W0455  There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview, the facility failed for 2 of 3 sampled clients (clients #1 and #2) by not ensuring they used proper sanitation methods while cooking or setting the table.  Findings include:  Observations were conducted on 8/22/11 from 4/00 PM to 6:15 PM at the group home. Client #1 got out a bag of frozen chicken nuggets and poured them onto a baking pan, using his bare hands to scrape some of them onto the pan. Client #1 had not washed his hands before handling the  The Agency maintains an active program for the prevention, control, and investigation of infection and communicable diseases.  System to Prevent Recurrence: The Agency maintains an active program for the prevention, control, and investigation of infection and communicable diseases.  The Agency maintains an active program for the prevention, control, and investigation of infection and communicable diseases.  The Agency maintains an active program for the prevention, control, and investigation of infection and communicable diseases.  The Agency maintains an active program for the prevention, control, and investigation of infection and communicable diseases.  The Agency maintains an active program for the prevention, control, and investigation of infection and communicable diseases.  The Agency maintains an active program for the prevention, control, and investigation of infection and communicable diseases.  The Agency maintains an active program for the prevention, control, and investigation of infection and communicable diseases.  The Agency maintains an active program for the prevention, control, and investigation of infection and communicable diseases.		had a PSA.						
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not washed his hands before handling the  The QA Team reviewed this								
			_					
food and there was no prompting from			_			_		
, , , , , , , , , , , , , , , , , , , ,		food and there w	as no prompting from			citation and concluded that it	was	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
			A. BUI	LDING	00	COMPLETED	
		15G327	B. WING			08/25/2011	
NAME OF I	PROVIDER OR SUPPLIEF		-	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	FRO VIDER OR SUFFLIER			417 N A	SH ST		
	COMMUNITY LIVING INC			L	R, IN46721		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	<b>+</b>	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	_	DATE
		them. Client #1 indicated			an issue of staff training and		
	at 5:30 PM that I	he had not washed his			it appears to be with a relativ	ely	
	hands first and th	hen he proceeded to wash			new staff person, Staff#1.		
	his hands. Clien	t #2 set silverware on the			Clients #1 and #2 have		
	table, touching the	he tops of some as he set			demonstrated previous	_	
	1	ent #2 also put his fingers			independence in these areas,		
		t bowls as he set them on			may need prompting on occa		
	the table.	t bowls as he set them on			There was a failure by this s	taff	
	uic table.				person to follow training		
	Interview on 8/23/11 at 12:50 PM with the QMRP (Qualified Mental Retardation				guidelines established for the		
					supervision of cooking and to		
					setting. Although this appea	rs to	
	Professional) wa	s conducted. She			be an isolated problem, the		
	indicated clients	should be prompted to			QMRP's were given training	in	
	wash their hands	s before cooking and they			techniques to observe staff		
		the tops of silverware			throughout the agency during		
	and inside bowls	•			meal preparation times, and		
		•			re-emphasize with all staff th	ie	
	1 1 2 7(0)				need to follow the training		
	1.1-3-7(a)				guidelines for ensuring prope	er	
					sanitation methods are used.		
					Given the past training for th		
					H1N1 flu prevention techniq		
					in particular, it was surprisin		
					that hand washing and the us		
					sanitation was not employed		
					prompted during the meal pr	•	
					The H1N1 training citing har		
					cleaning and the use of sanita		
					agents is to be emphasized in		
					orientation training to ensure	that	
					this issue does not recur.		
					Responsible: CEO		

000845

AND PLAN OF CORRECTION ID		IDENTIFICATION NUMBER:  15G327	A. BUILDING  O		COMPLETED 08/25/2011			
		100021	B. WING					
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 417 N ASH ST					
COMMUI	NITY LIVING INC		I	ER, IN46721				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX TAG		CY MUST BE PERCEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE			
IAG	REGULATORT OR	LSC IDENTIFYING INFORMATION)	IAG	<u> </u>	DATE			
W0488	in a manner consist developmental lev	ation, record review and	W0488		lble , , , , , , , , , , , , , , , , , , ,			
	additional client ensuring he serve as independently  Findings include  Observations were home on 8/22/11  PM. Client #4 whimself instant comanager's verbal	(client #4) by not ed himself his breakfast as possible.		Agency assures that each cleats in a manner consistent his or her developmental leven system to Prevent Recurre. The QA Team reviewed this citation and concluded that is appeared to be an issue of straining and that it appears the with the same relatively new person, Staff#1, who was cit W455. There was a failure this staff person to follow traguidelines established for the supervision of individuals preparing and cooking their breakfasts as independently	with el. nce: t also staff to be t staff ed in by ining e			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15G327 08/25/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 417 NASH ST COMMUNITY LIVING INC BUTLER, IN46721 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE sandwich with no assistance or prompting possible Although this appears to be an isolated problem with this from staff. individual staff person, the QMRP's were given training in Observations were conducted at the group techniques to observe staff throughout the agency during home on 8/23/11 from 6:28 AM to 7:45 morning meal preparation times, AM. Staff #1 measured the water and and to re-emphasize with all staff heated it up in the microwave for client the need to follow the training #4, who was not in the kitchen at this guidelines for ensuring that time. Staff #1 poured client #4's prune Consumers are as independent as possible. There is the juice for him and mixed the heated water question whether the breakfast and the oatmeal in a bowl and set it on the was prepared for the client as a table. Client #4 was not in the kitchen or convenience for the staff or if the dining room at this time. Then staff #1 staff genuinely did not understand his role in the meal preparation in stirred client #4's oatmeal for him as the mornings. Since convenience client #4 sat down to eat. Staff #1 did not may also be a possibility of prompt client #4 at all during this prompting other agency staff to observation to make his oatmeal or pour do more for consumers in the mornings than needed, the his prune juice. QMRP's were given training in techniques to observe staff Review on 8/23/11 at 12:30 PM of client throughout the agency during #4's "Individual Supports and Assessment morning meal preparation times, and to re-emphasize with all staff Planning Guide" dated 3/2/11 indicated the need to follow the training client #4 could prepare a meal "with 1:1 guidelines for ensuring that each (one-on-one) supervision." Under "Use consumer eats and prepares appliances correctly" it indicated "Does breakfast in as independent manner as possible. skill independently, including Responsible: CEO Completed: self-initiates. . .: Under "Follows recipe", 09/13/2011 1. Staff #1 is it indicated he "Knows skill; however, trained to allow and encourage lacks motivation or interest and needs each consumer to eat and prepare breakfast in as prompts." Under "Cooks and bakes to independent manner as possible. doneness", it indicated he "Completes Responsible: QMRP skill with 1:1 supervision." Completed: 09/16/2011 Interview on 8/23/11 at 6:35 AM with

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1J4T11

Facility ID:

000845

If continuation sheet

Page 8 of 9

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/26/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  15G327		A. BUILD B. WING		00 	COMPL 08/25/2	ETED			
	NAME OF PROVIDER OR SUPPLIER  COMMUNITY LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 417 N ASH ST BUTLER, IN46721					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE		
		ducted. Staff #1 indicated t make oatmeal himself.							
	the house manag house manager s prompts but was The house manag could measure of and push the nun to heat the water	4/11 at 11:45 AM with er was conducted. The tated client #4 needed "not totally helpless." ger indicated client #4 at water for the oatmeal inbers on the microwave. He also indicated client is own prune juice.							

000845